WHERE THERE IS NO FUNDING

The need for a community-based approach to health delivery in Nkwanta District of the Volta Region is seemingly obvious. The district is vast, spanning a rugged terrain in the northern-most area of the Volta Region bordering on Togo and Lake Volta, and comprising 5,500 square kilometers over a distance of 140 kilometers from north to south. A population of 187,000 people live in dispersed settlements. There is only one doctor in the area, and even paramedics are scarce. The nurse-to-patient ratio, for example, is estimated to be 1:9,000.

Community members at CHO durbar

Even staff doing their best in such circumstances do not succeed. Data on the impact of services consistently fell below expectations, seeming to some to reflect poor health service performance. Mr. Adamu Issaka of the Nkwanta District Health Management Team (DHMT) explained this sense of failure by noting:

> *"Over the years, the indicators of poor health conditions was a worry to the DHMT because the problems seemed to indicate low coverage and low worker performance. When we presented health indicators at national and regional conferences, we were sometimes the subject of ridicule, because we were among the worst performers in the country."*

But poor performance was a direct result of having no revenue. Not only was the district isolated, it was cut off from donor resources, tax returns, or community funding of any kind.

In 1998, the DHMT met and resolved that solutions to problems would be found that relied on local resources. An initiative known in the district as "Reaching the Unreached" was launched. This programme was dedicated to finding practical means of solving problems, organizing community health, and bringing service resources to every doorstep. The team visited the Navrongo Health Research Centre, reviewed the operations of the Community Health and Family Planning Project (CHFP), and selected parts of the programme that could be started without external assistance. "Reaching the Unreached" was a simplified version of the programme that eventually became the national Community-based Health Planning and Services (CHPS) Initiative. At its onset, there were no motorbikes, bicycles, community clinics, or any other elements of the Navrongo programme that required extra funding.

Visiting teams meeting CHO in Bontibor zone

The initial DHMT task in "Reaching the Unreached" concerned identifying existing resources. Although there were no community clinics and no motorbikes, communities were willing to develop temporary quarters and workers were willing to be relocated to village locations. Communities provided accommodation, support to the nurse, and enthusiastic backing for the

programme. Access to health care improved, even in the absence of motorbikes. Over the course of a year, there was a gradual build up of community-based care on the "Reaching the Unreached" model—funded totally from local resources.

Achievement and dissemination of this success attracted interest from the Regional Health Management Team, leading to support from the Regional Health Administration. In presentations to other DHMT, Nkwanta emphasized that community health care could begin by using existing resources. These resources were:

- *Cultural resources.* Even in the most impoverished district, community leadership exists and community commitment can be mobilized for volunteer support for renovation or construction.
- *Abandoned or partially constructed facilities.* Many communities have partially constructed or abandoned structures that can be repaired and used for community clinics at low cost.
- *Community demand for care.* Where the district health facilities are far from communities, posting a nurse to a village greatly improves access. Patients will walk to a Community Health Compound (CHC) for services. Major progress can be made by starting CHC care, even if motorbikes are not available.

Success in implementing CHPS-generated DHMT morale, and the contagion of success has reached workers at all levels. Once a few zones were functioning, programme momentum grew in the communities of Nkwanta District—awareness of health services led to demand and community-based care spread throughout the district.

Action led to funding: Visible progress in the initial CHPS zones led to regional programme interest in adding revenue for expansion. This partnership between the district and the region generated more progress and attracted attention among grassroots development workers at World Vision. They donated building materials that volunteer community teams used to construct two permanent CHC. DANIDA then donated four motorbikes. Finally, World Vision provided cement and roofing sheets for constructing three additional CHC; communities donated lumber, sand, and labour. CHPS is now being sustained and scaled up with additional community-donated facilities, labour, and organizational backing.

For this reason, the Nkwanta team are advising all other CHPS implementers to focus on developing services in one or two zones, getting it right on a small scale, and then campaigning for district funding, regional support, and external resources on the basis of success. Where there is no funding, success breeds success.

Regional Directors of Health on
field visit to Sibi CHPS zone